(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

MUSCULOSKELETAL PAST & PRESENT MEDICAL SCREENING FORM

OTSG APPROVED *(Date)*

MARK EACH ITEM IN QUESTIONS 1 - 4 "YES" or "No".

1. Have you or any immediate family member ever been told you have:	**FAMILY YES**	**FAMILY NO**	**SELF YES**	**SELF NO**
a. Cancer	☐	☐	☐	☐
b. Diabetes	☐	☐	☐	☐
c. High blood pressure	☐	☐	☐	☐
d. Heart disease	☐	☐	☐	☐
e. Angina or chest pain	☐	☐	☐	☐
f. Stroke	☐	☐	☐	☐
g. Osteoporosis	☐	☐	☐	☐
h. Osteoarthritis	☐	☐	☐	☐
i. Rheumatoid arthritis	☐	☐	☐	☐

2. In the past 3 months, have you had or are you currently experiencing:	**YES**	**NO**
a. A change in your health	☐	☐
b. Nausea or vomiting	☐	☐
c. Fever, chills or sweats	☐	☐
d. Unexplained weight change	☐	☐
e. Numbness or tingling	☐	☐
f. Changes in appetite	☐	☐
g. Difficulty swallowing	☐	☐
h. Changes on bowel or bladder function	☐	☐
i. Shortness of breath	☐	☐
j. Dizziness	☐	☐
k. Upper resipratory infection	☐	☐
l. Urinary tract infection	☐	☐
m. Change in your balance (increased falls)	☐	☐

3. Do you have a history of:	**YES**	**NO**
a. Allergies or asthma	☐	☐
b. Headaches	☐	☐
c. Bronchitis or COPD	☐	☐
d. Kidney disease	☐	☐
e. Rheumatic fever	☐	☐
f. Ulcers	☐	☐
g. Sexually transmitted disease	☐	☐
h. Siezures	☐	☐

4. Are you currently:	**YES**	**NO**
a. Pregnant	☐	☐
b. Depressed	☐	☐
c. Under stress	☐	☐

5. Are your symptoms: (check one)

☐ Getting worse ☐ The same ☐ Improving

6. How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty ☐ Only with medication

7. Do you have a problem with: (check all that apply)

☐ Hearing ☐ Speech ☐ Vision ☐ Communication

8. I feel worse in the: (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

9. I feel best in the: (check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

10. Smoking	**YES**	**NO**
a. Do you or have you in the past smoked tobacco?	☐	☐
b. If "YES", _____ packs X _____ years.		
c. If "YES", Last tobacco use:		

11. Alcohol	**YES**	**NO**
a. Do you drink alcoholic beverages?	☐	☐
b. If "YES", how many drinks do you usually have per week?		

12. Date of your last physical exam:

13. List all prescription medications, over-the-counter medications and herbals that you are current taking:

_____

_____

_____

_____

_____

_____

Patient's signature

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT